EMPLOYEE TIME SHEET

EMPLOYEE NAME: _____
SSN # (LAST 4 DIGITS ONLY): _____

FACILITY NAME: _____
CITY/STATE: _____

P.O. Box 1731
Eagle, ID 83616
FAX (208) 378-1358

If you would like to confirm your timecard was received, please text 208-559-5183.

*Fill out one time card for each facility worked each week

Day	Date	Unit	Time In	Time Out	Lunch	Regular Hours	OT	Holiday	Orientation	On-Call	Call-Back	Charge Nurse	Travel	**DAILY TOTAL**	Hospital Rep. Initials
SUN															
MON															
TUE															
WED															
THU															
FRI															
SAT															
				WEEKLY TOTAL											

Employee Signature: _____

Reminder: Don't forget to 'swipe' or use any Kronos system.

Hospital Representative Signature: _____

TIME CARDS ARE DUE IMMEDIATELY FOLLOWING LAST SHIFT OF THE WEEK.
Hospital Rep. Initials Required for any OT Hours (over 40/week)